AFES SECTION 125 FLEXIBLE BENEFIT PLAN
EXPENSE REIMBURSEMENT VOUCHER

Name of Employee (Last, First, MI)	**Social Security #**
Mailing Address ☐ *Check here if this is a new address; if so, do you have other AF products?*	**E-mail address**
Name of Employer	**Daytime Phone #**

Date of Expense	**Name of Person for Whom the Expense Was Incurred**	**State Tax Law Eligible (If Incurred for a Dependent and residing in Wisconsin)***		**Amount of Medical Expense**
		Yes	**No**	
			Expense Total: (must be completed)	$ 0.00

ALL DOCUMENTATION ATTACHED MUST HAVE A DETAILED EXPLANATION OF THE DATE, TYPE, AND AMOUNT OF EACH SERVICE RENDERED. REIMBURSEMENTS CANNOT BE MADE UNTIL THE FIRST DEPOSIT OF EACH PLAN YEAR HAS BEEN RECEIVED FROM YOUR EMPLOYER.

Acceptable Documentation to accompany the reimbursement voucher:

√ Professional bill or receipt that includes:
- Provider of service
- Type of service rendered
- Charges for the service
- Original date of service

NOTE: the date of service, not the date of payment must fall within the dates of the plan year for which you are enrolled)

√ Insurance Company Explanation of Benefits

√ Pharmacy Statement that includes Rx number and name of prescription

√ ***Over-the-counter drugs and medicine - medical practitioner's prescription and receipt required.***

Unacceptable Documentation includes:

√ Cancelled checks or credit card receipts

√ Bill or receipt that only shows a balance forward/ previous balance or payment due

I authorize the above expenses to be reimbursed from my Health FSA (Unreimbursed Medical Expense) account. To the best of my knowledge my statements on this form are true and complete. I certify that either I, my spouse, or my dependent (qualifying child or qualifying relative as defined in Code Section 152*)* or qualifying adult child (as amended in Code Section 105 to be included as a dependent with respect to benefits provided after March 30, 2010) has received the services described above on the dates indicated and that the expenses qualify as valid medical care expenses under Code Section 213 (d). I certify that these expenses have not been reimbursed, nor will I seek reimbursement, under a major medical plan or any other health plan, such as an individual policy or my spouse's or dependent's health plan, a Health Savings Account, or Health Reimbursement Arrangement. I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit. I further understand that I may be asked to provide further documentation or further detail relating to an expense.

* *You only need to complete this box if you live in* ***Wisconsin.*** As a general rule, employees pay no FICA, federal, or state income taxes on employer or employee Health FSA contributions or reimbursements. However some state tax rules do not allow the tax-free treatment that applies under federal law and, therefore, Health FSA reimbursements may need to be included in my income for state tax purposes. I have verified and appropriately indicated, to the best of my knowledge, whether each dependent for whom an expense was incurred is a state tax-qualified dependent in the state where I reside.

Signature of Employee **Date Signed**

Mailing Address: American Fidelity Assurance Company, AFES Flex Account Administration, PO Box 25510, Oklahoma City, OK 73125-0510 **PHONE NUMBER:** 1-800-325-0654 **FAX NUMBER:** 1-800-543-3539

American Fidelity will not be responsible for faxes not received. Average processing time is 5 to 7 working days from receipt of a completed voucher. Additional Forms and Account Information are available on our website at: www.afadvantage.com – forms for **Education Employees**.

INCOMPLETE VOUCHERS MAY DELAY PROCESSING OR RESULT IN A DENIED CLAIM

KEEP A COPY OF ALL CLAIMS SUBMITTED FOR YOUR RECORDS